Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3531AGC	A. BUILDING _____ B. WING _____	12/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWICH ASSISTED LIVING CTRS, LLC	3226 KEMP STREET N LAS VEGAS, NV 89032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 15417 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an attempted annual State Licensure survey conducted at your facility on 12/29/09. There was no one present at the facility at the time of the attempted survey. The facility did not receive an annual survey grade. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is currently under renovation. The facility does not have any residents residing at the facility and the facility does not plan to admit any residents until Spring of 2010. The facility was licensed as a Residential Facility for Groups which provides care for 6 elderly or disabled persons. The facility has one (1) Category I bed and five (5) Category II beds. At the time of the attempted onsite survey, the exterior appeared well maintained. The south entrance gate had a small pad lock which prohibited entrance into the backyard. All blinds were closed and there was no way to see inside of the facility. Please contact the Bureau of Healthcare Quality & Compliance at 702-486-6515 regarding the status and intent of the operation of your facility.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

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Y 000	Continued From page 1 If you are anticipating operating as a licensed facility, an annual survey is mandatory in order to maintain your licensure.	Y 000		